Print Form

All required forms must be received prior to scheduling travel arrangements for the National finals.

U.S. DEPARTMENT OF ENERGY
2009 National Science Bowl ®**for High School Students**
Adult Confidential Medical Information and Emergency Notification Form
(Please fill out the entire 3-page form)

This is a PDF Form filler document. Click on the space and type in the information requested. Once the form is complete: (1) click "File," then "Save As" and give it a name and save it on your computer; (2) print the completed form; (3) parent/guardian or student (if 18) must sign it in blue ink (preferred); (4) give this form to the coach; (5) coach to give all completed forms to the regional coordinator. ***No blank lines allowed; write N/A if needed.***

School _____

Name _____ Birth Date [ ] Sex: M ○ F ○

Street Address _____

City _____ State _____ Zip Code _____

Home Telephone ( ) _____ SSN _____
(only necessary for National event)

IN CASE OF EMERGENCY, CONTACT:

Primary Contact		Secondary
_____	Name	_____
( ) _____	Phone	( ) _____
( ) _____	Cell Phone	( ) _____
_____	Relationship	_____

Allergies

Yes	No		If Yes, specify
○	○	Medication:	_____
○	○	Food	_____
○	○	Environmental	_____

Medical History (To include surgeries)

Date of Last Tetanus Shot: [ ]

(A) Current/Recent Medical History/surgery (within the past 12 months)

_____

_____

All required forms must be received prior to scheduling travel arrangements for the National finals.

(B) Other Pertinent Medical History/surgery

_____
_____
_____
_____

Medication Information (Prescribed and Over-the-Counter Medications and Purpose)
Follow the format listed below.

Prescribed Current Medications

Medication/Dosage	Purpose/Used
(Example: Albuterol/10mg per day)	(Example: Asthma)

Over the Counter

Medication	Purpose/Used
(Example: Advil/as needed)	(Example: Headaches)

Physical Limitations/Needs (Please include any Assistive Devices that need to be provided):

Mobility Limitations _____
Visual Limitations _____
Communications Limitations _____

Vegetarian/Kosher Diet Preferences: _____

All required forms must be received prior to scheduling travel arrangements for the National finals.

Religious or Cultural concerns that may affect care: (e.g. No Blood Transfusions)

_____

HEALTH INSURANCE

_____ _____

Physician Insurance

YES ○ NO ○

_____ Name _____

( ) _____ Phone ( ) _____

Policy # _____

CONSENT TO MEDICAL CARE AND TREATMENT

I hereby authorize and consent to the administration of all medical and/or surgical treatment(s) to my child by a licensed physician, nurse or hospital in the event I am not available to consult with the attending physician(s), attempts to contact me have been unsuccessful, and the attending physician(s) deem it advisable to proceed with such treatment(s).

_____

(Print Name of Student)

_____ Date _____

Signature of Parent/Legal Guardian (or Student if 18) in Blue Ink

NO FAX COPIES